

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **JOSE H. ALVAREZ, M.D.**

4 Holder of License No. 21702  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Case No. MD-14-1074A

**FINDINGS OF FACT, CONCLUSIONS  
OF LAW AND ORDER FOR LETTER  
OF REPRIMAND**

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 December 2, 2015. Jose H. Alvarez, M.D. ("Respondent"), appeared with legal counsel  
9 Michael Navratil, Esq., before the Board for a formal interview pursuant to the authority  
10 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact,  
11 Conclusions of Law and Order after due consideration of the facts and law applicable to  
12 this matter.

13 **FINDINGS OF FACT**

14 1. The Board is the duly constituted authority for the regulation and control of  
15 the practice of allopathic medicine in the State of Arizona.

16 1. Respondent is the holder of license number 21702 for the practice of  
17 allopathic medicine in the State of Arizona.

18 2. The Board initiated case number MD-14-1074A after receiving a complaint  
19 regarding Respondent's care and treatment of a 33 year-old female patient ("SG") alleging  
20 that Respondent failed to properly treat the patient.

21 3. SG began treatment with Respondent on September 5, 2013, for obstetrical  
22 care at 16 weeks pregnant. Respondent referred SG to a perinatologist after a positive  
23 test for Down's Syndrome. The perinatologist identified multiple fetal abnormalities and  
24 ultimately on October 7, 2013 fetal demise was confirmed by ultrasound.  
25

1           4.     On October 8, 2013, SG was admitted to the hospital in order for  
2 Respondent to perform an induction. Respondent gave SG Cytotec by three vaginal doses  
3 and one oral dose. Respondent evaluated SG at 4:40 p.m. and recommended a 24-hour  
4 break due to lack of progress. SG was discharged at 7:00 p.m.

5           5.     SG delivered the fetus at home and returned to the hospital at 7:45 a.m. on  
6 October 9, 2013. At the time of admission, SG had not yet delivered the placenta.  
7 Respondent ordered Cytotec to be given to SG upon admission and again at 11:30 a.m.  
8 SG delivered the placenta at 3:45 p.m. and was discharged again at 6:00 p.m. There is no  
9 documentation regarding the course of SG's hospitalization other than "post-partum" notes  
10 by nurses at 5:30pm and 5:45pm, along with a brief hand-written note by Respondent.

11          6.     On October 27, 2015, SG presented to the emergency room after passing 2  
12 large clots, though she had stopped bleeding 10 days after delivery. SG continued to bleed  
13 heavily with clots and cramping. On November 4, 2013, laboratory studies were carried out  
14 and an ultrasound revealed a complex mass in the superior posterior myometrium. SG's  
15 diagnosis included possible retained products of conception.

16          7.     On November 5, 2013, SG was seen by another physician. An evaluation  
17 was carried out and her uterus was noted to be tender. Cipro and Flagyl were prescribed  
18 and toxoplasmosis and CMV evaluations undertaken. The toxoplasmosis screen was  
19 negative and the CMV titer indicated prior infection.

20          8.     During a Formal Interview on this matter, Board members commented that it  
21 was difficult to determine what occurred in the case since Respondent had very few notes,  
22 and that there was little documentation regarding alternative therapies being discussed.  
23 Board members also noted that it was difficult to determine Respondent's treatment  
24 rationale regarding SG's care.

1 CONCLUSIONS OF LAW

2 1. The Board possesses jurisdiction over the subject matter hereof and over  
3 Respondent.

4 2. The conduct and circumstances described above constitute unprofessional  
5 conduct pursuant to A.R.S. § 32-1401(27)(e) ("failing or refusing to maintain adequate  
6 records on a patient.").

7 ORDER

8 IT IS HEREBY ORDERED THAT:

9 1. Respondent is issued a Letter of Reprimand for inadequate medical records  
10 in violation of A.R.S. § 32-1401(27)(e).

11 DATED AND EFFECTIVE this 22<sup>nd</sup> day of January, 2016.

12 ARIZONA MEDICAL BOARD

13 By Patricia E. McSorley  
14 Patricia E. McSorley  
15 Executive Director

16 RIGHT TO PETITION FOR REHEARING OR REVIEW

17 Respondent is hereby notified that he has the right to petition for a rehearing or  
18 review. The petition for rehearing or review must be filed with the Board's Executive  
19 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The  
20 petition for rehearing or review must set forth legally sufficient reasons for granting a  
21 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after  
22 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,  
23 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

24 Respondent is further notified that the filing of a motion for rehearing or review is  
25 required to preserve any rights of appeal to the Superior Court.

1 EXECUTED COPY of the foregoing mailed  
2 this 22<sup>nd</sup> day of January, 2016 to:

3 Michael Navratil, Esq.  
4 John H. Cotton & Associates, Ltd.  
5 7900 W. Sahara Ave., Suite 200  
6 Las Vegas, Nevada 89117-7921  
7 Attorney for Respondent

8 ORIGINAL of the foregoing filed  
9 this 22<sup>nd</sup> day of January, 2016 with:

10 Arizona Medical Board  
11 9545 E. Doubletree Ranch Road  
12 Scottsdale, AZ 85258

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Board Staff